

NATIONAL HEALTH INSURANCE PROPOSAL

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National Health Insurance Proposal

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ACRONYMS

ANC	Ante-natal care
GDP	Gross Domestic Product
HIFTAC	Health Insurance and Financing Technical Advisory Committee
ILO	International Labor Organization
MoHSS	Ministry of Health and Social Services
NHI	National Health Insurance
NHIS	National Health Insurance Scheme
NMBF	National Medical Benefits Fund
PPPs	Public private partnerships
PSEMAS	Public Service Medical Aid Scheme
PVHI	Private voluntary health insurance
SHI	Social Health Insurance
SPF	Social Protection Floor
SSC	Social Security Commission
UHC	Universal Health Coverage

1. Executive Summary

Namibia's classification as an Upper Middle Income Economy by the World Bank to a great extent masks some very large income inequalities in the country. Namibia's Gini coefficient historically ranks among the highest in the world¹ and current World Bank estimates suggest that up to 38 percent of Namibians live in poverty.² Health inequalities are embedded in such wealth inequalities.

Total health spending as a percentage of GDP is 6.8 percent, while government health care spending as a percentage of total government spending has decreased from 14.3 percent in 2008/09 to 9 percent in 2011/12 and 9.95 percent in 2012/13 - still short of the Abuja Declaration target of 15 percent. While health care financing is primarily tax-based in Namibia, donors still contributed 21.7 percent to health spending in 2008/09. However, donor contributions are expected to decrease substantially in coming years as a result of Namibia's classification as an Upper Middle Income Economy, and this places increased pressure on the Namibian Government to identify means for sustainable health care financing.

In recent years, governments across the world, including the Government of the Republic of Namibia, have recognized the importance of providing equitable access to health care for their citizens and have reaffirmed their commitment to achieving Universal Health Coverage (UHC), which is defined as "access to key promotive, preventative, and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access". This was also endorsed as part of the World Health Assembly Resolution 58.33 (2005) that urges member states to "ensure that health financing systems include pre-payment methods with views to sharing risk among populations and avoiding catastrophic health care expenditure".³

While the private-for-profit and not-for-profit sectors play an important role in the provision of health services, the health system in Namibia is dominated by the public sector. One of the factors hampering access to services is the vastness of the country with most of the country being thinly populated outside urban centers in the middle and the south of the country. All public health facilities in Namibia are expected to charge some form of user fees, but exemption from payment of these fees is provided for certain services including, but not limited to, testing for notifiable diseases, preventive and promotive services, and chronic diseases and for vulnerable groups and pensioners. Despite these discounts for vulnerable groups and pensioners there is a risk that user fees can be a barrier to access to services by the most vulnerable populations, leading to poor health outcomes. Since access and equity are key priorities for many low- and middle-income countries because of the strong link between poverty and disease burden, the option of implementing health insurance is being considered by many of these countries as it protects the citizens by reducing the need to pay for health services at the point of delivery and improves health outcomes by decreasing barriers to access.

The overall objective of National Health Insurance (NHI) is to promote equitable access to sustainable and optimum quality health care and providing increased financial protection for the country's citizens. The institutional arrangements of NHI should provide for a more sustainable

¹ The United National Development Programme estimated Namibia's Gini Coefficient at 0.63 in 2007.

² The World Bank: <http://data.worldbank.org/country/namibia>.

³ *Sustainable health financing, universal coverage and social health insurance* [A58/33]. Geneva: WHO; 2005

means of health care financing than the provision of free health care through public and charity services. NHI is mandatory for all citizens and can thus positively influence equity by pooling the risk of illness or injury over the entire country's population regardless of their income level. Cross-subsidization from the wealthy to the poor and government subsidies can further reduce the financial burden on low-income individuals. As a single-pool organization, a NHI scheme with a guaranteed benefits package available to all citizens can also benefit from economies of scale, which potentially makes the system more efficient, cost-effective and easier to administer. In a well-regulated environment, risk-pooling approaches can often be combined to include both public and private actors, encouraging healthy competition and provider choice. The fact that Namibia has a reasonably well-developed private health insurance market would allow the Namibia Government to focus on covering the uncovered population and also learn from the experience of the private schemes. In particular, the government can focus on making premiums affordable, designing an optimum benefits package for specific populations and improving the financial risk protection for the bulk of the population.

The Ministry of Health and Social Services (MoHSS) has the mandate of addressing the social needs of vulnerable groups, which includes the promotion of access to essential services and social transfers for these populations. As a result, it was determined that within the Namibia Government the MoHSS should also be mandated with the achievement of UHC. While the MoHSS has this mandate for UHC, the Social Security Commission (SSC) has a mandate for the establishment of a National Medical Benefits Fund (NMBF) which shall provide "for the payment of medical benefits to employees". While the NMBF was initially conceived as a form of Social Health Insurance (SHI), it could potentially serve as a sub-set of a greater NHI scheme. It is therefore recommended that MoHSS works towards the achievement of UHC by designing a NHI scheme that compliments the coverage of the proposed NMBF and existing private health insurance schemes. Given its mandate with the NMBF, the SSC can provide technical assistance to define the depth and breadth of a national benefit package of health services, determine its cost and its long-term financial requirements for NHI.

During a Health Insurance Workshop held in September 2011 a proposal and terms of reference for the establishment of a National Health Insurance and Financing Technical Advisory Committee (HIFTAC) was presented and endorsed in principle. This Committee has the objective of providing advice and guidance to the MoHSS on the development of NHI in Namibia with a focus on evaluating evidence and potential models. The members of HIFTAC are drawn from a variety of institutions and represent a broad range of relevant disciplines; however, they are mostly representatives who are in full-time employment and will therefore not have sufficient time to operationalize the key decisions made. It is therefore recommended that a formal Secretariat is created with full-time staff to manage the day-to-day activities of establishing NHI.

Two major phases of developing and implementing NHI are proposed: the preparatory phase and the implementation phase. The key steps under the preparatory phase include ensuring national ownership of the implementation of NHI, establishing a multi-sectoral technical committee, learning from the experiences of other countries, understanding the current situation in Namibia and future prospects, defining the health financing model, defining the key parameters and consulting with various stakeholders. The implementation phase would include: the enactment of laws to provide legal sponsorship, setting up the administrative structures, developing standards and detailed

operational manuals, undertaking awareness campaigns and communication, and ensuring effective collaboration with key sectors.

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2. Introduction

Health Spending

Namibia is classified as an Upper Middle Income Economy by the World Bank. However, this ranking masks some very large income inequalities. Namibia's Gini coefficient, an international measure of income and wealth distribution, historically ranks among the highest in the world.⁴ Current World Bank estimates suggest that up to 38 percent of Namibians live in poverty.⁵ Health inequalities are embedded in such wealth inequalities, and Namibia ranks 120 out of 187 countries on the United Nations' Human Development Index, a measure of countries' progress on indicators in Health, Education, and Income.⁶

Namibia's per capita spending on health, N\$2,410 in 2008/09, compares favorably with other countries in the region. Health care financing in Namibia is primarily tax-based. Total health spending as a percentage of GDP is 6.8 percent. Government health care spending as a percentage of total government spending has decreased from 14.3 percent in 2008/09 to 9 percent in 2011/12 and projected at 9.95 percent in 2012/13 - still short of the Abuja Declaration target of 15 percent. User fees for health services are in place in the public sector, and out-of-pocket expenditures as a percent of total health spending is 6 percent. International partners provide financial support to specially targeted programs such as HIV/AIDS, malaria and tuberculosis treatment and prevention. As a result of Namibia's classification by the World Bank, donor aid is expected to decrease within a few years. In 2008/09, donor contributions to health spending in Namibia were 21.7 percent, while the private sector contribution was 12.2 percent. In 2008/09, the national HIV/AIDS response alone consumed 27.5 percent of total national expenditures on health.⁷ There is an increasing shift of donor aid from implementation of prevention and treatment programs to the sustainability of health care financing, which points to the need for the Namibian Government to increase its spending on the implementation of such programs.

Access to Health Care

The Ministry of Health and Social Services (MoHSS) is the primary implementer and provider of public health services in Namibia through a four tier system: outreach points (1,150), clinics and health centers (309), district hospitals (29), and intermediate and referral hospitals (4). Voluntary community health workers provide services at the community level, however, a review of this program in 2006 found it to be unsustainable due to attrition of volunteer health workers. Traditional medicine is widely used in the country and often the first port of call. However, there is no regulation of the practice of traditional medicine.

⁴ The United National Development Programme estimated Namibia's Gini Coefficient at 0.63 in 2007.

⁵ The World Bank: <http://data.worldbank.org/country/namibia>.

⁶ UN Development Programme. Namibia Human Development Indicator Profile. <http://hdrstats.undp.org/en/countries/profiles/NAM.html>.

⁷ Government of Namibia, Health Systems 20/20 Project, World Health Organization, and uNAID. December 2012. Namibia Health Resource Tracking: 2007/08 & 2008/09. Bethesda, MD: Health Systems 20/20 Project, Abt Associates, Inc.

While the MoHSS is the primary provider of public health services, the private-for-profit and not-for-profit sectors also play a substantial role in health services. There are 844 private health facilities registered with the MoHSS, among which there are 13 hospitals, 75 clinics, and 8 health centers. These facilities are mainly located in urban areas within the Erongo and Khomas regions. Seventy-two percent of doctors in Namibia and slightly less than 50 percent of registered nurses are in the private sector. Faith-based organizations operate services on an outsourcing basis.

A full package of basic services is available in 70 percent of health facilities. These basic services include: outpatient care for sick children and services for adult STIs, temporary methods of family planning, ante-natal care (ANC), child immunization, and child growth monitoring. Health centers are more likely than other facility types to offer all these basic services. Two-thirds of all facilities offer these services at minimum frequencies⁸. A full package of services available at the minimum frequency, together with 24-hour facility-based delivery services, is available in one-quarter of all health facilities. Eighty percent of facilities have basic client comfort amenities, and approximately 60 percent of facilities have regular, year-round access to water. Half of all facilities have regular access to electricity. All basic client amenities (basic level of cleanliness, no broken equipment, and no obvious dirt or boxes lying around), a year-round water supply, and regular electricity are all available in only 30 percent of facilities.⁹

Access to service is hampered by the vastness of the country with most of the country being thinly populated outside urban centers in the middle and the south of the country. Sixty percent of the population is concentrated in the north, where there is also a concentration of health facilities. It is estimated that 21 percent of the population is living more than 10 kilometers away from a health facility. Namibia's projected population growth remains at 1.87 percent and the government anticipates continued growth in demand for health services.

Universal Health Care

In recent years, governments across the world have undertaken the task of working out the best way to achieve universal health coverage (UHC) for its citizens. UHC is defined as “access to key promotive, preventive, curative, and rehabilitative health interventions for all at an affordable cost, thereby achieving equity in access.” Universal coverage reforms are a key element of the World Health Organization's (WHO) ultimate goal of better health for all. This is also articulated and endorsed in the World Health Assembly Resolution 58.33 (2005) entitled “sustainable health financing, universal coverage, and social health insurance.” This resolution urges member states to “ensure that health financing systems include pre-payment methods with a view to sharing risk among the population and avoiding catastrophic health care expenditure.”¹⁰

Pre-paid schemes, such as health insurance, are a notable means to universal coverage as evidenced by several countries in Africa (Ghana, Kenya, Rwanda, Senegal, the United Republic of Tanzania, and Uganda) and Asia (China, India, the Philippines and Vietnam). Markedly, Thailand is achieving universal coverage at a low cost (public spending on health care is less than 4 percent of GDP)

⁸ The 2009 Namibia Health Facility Census defines services at minimum frequencies as follows: outpatient curative care services for children offered at least five days per week; STI services at least one day per week; preventive or elective services (any temporary methods of family planning, ANC, child immunizations, and child growth monitoring) at least one day per week.

⁹ The 2009 Namibia Health Facility Census, February 2011.

¹⁰ *Sustainable health financing, universal coverage and social health insurance* [A58/33]. Geneva: WHO; 2005

through a mechanism that improved access to health service and offered financial risk protection. The insurance scheme in Thailand consolidated several health funding pools into one pool covering 47 million people.

An insurance scheme is defined by its provision of financial risk protection against specific perils in exchange for regular premium payment proportionate to the likelihood and cost of the risks involved. For health insurance schemes to promote progress towards achieving universal coverage, governments must ensure inclusion of low-income and vulnerable populations. Low-income populations have shown strong solidarity when they bound together and confront the cost of disease. In African countries, where the economy is mostly informal, a *mutuelle* scheme brings consumers under health insurance through a combination of government financing, and individual payments as low as US\$1 per year.

Namibia has reaffirmed its commitment to achieving UHC for all segments of its population. However, there is a long way ahead to fully realize this commitment. The Government of the Republic of Namibia implements a medical scheme for civil servants, which is the largest insurance program in Namibia. This program, called the Public Service Medical Aid Scheme (PSEMAS), is financed both by employees and by the National Treasury. PSEMAS covers government employees on a voluntary basis, yet only 51 percent of the civil servants are currently enrolled.

Private insurance companies provide health insurance policies for private sector employees, yet in total only about 18 percent of the Namibian population are currently insured. This calls for designing a system that provides coverage for the remaining uninsured portion of the Namibian population.

The health system in Namibia is dominated by the public sector which provides universal coverage for a limited set of services and is predominantly financed through general taxation. Services such as routine immunization for infants are free in government facilities. All facilities in Namibia are expected to charge some form of user fees. User fees were introduced to enhance efficiency by encouraging patients and clients to enter the health services at lower level facilities and hence contribute to the decongestion of secondary and tertiary level facilities. Furthermore, user fees were designed to improve the patient's understanding that he or she needs to value the services received, an understanding that should contribute to better compliance, cooperation, and quality assurance. Exemption from the payment of user fees is provided for certain services that include, but are not limited to, testing for notifiable diseases, preventive and promotive services, and chronic diseases and for vulnerable groups and pensioners. However, providing exemptions or discounts for low-income clients can result in budget shortages if there is no system for reimbursing these exempted or discounted costs.¹¹

While evidence suggests that user fees can have some success in increasing access to drugs, they may also contribute to reduced access to services for the most vulnerable populations, resulting in reduced service utilization and poor outcomes. Many countries in Africa have abolished user fees in public health facilities, including Uganda in 2001 and Zambia in 2006, in favor of health insurance and free-care policies to reduce financial barriers at the point of service. One alternative to address poor health

¹¹ The 2009 Namibia Health Facility Census defines services at minimum frequencies as follows: outpatient curative care services for children offered at least five days per week; STI services at least one day per week; preventive or elective services (any temporary methods of family planning, ANC, child immunizations, and child growth monitoring) at least one day per week.

outcomes and inequalities is to invest in health insurance. Evidence suggests that there is a proven market for health insurance in Namibia, but it is unlikely that currently available private health insurance schemes can reach the two lowest income quintiles, even with subsidies.¹² Hence the attractiveness for exploring the option of a National Health Insurance scheme (NHI).

Access and equity are key policy priorities for many low- and middle-income countries because of the strong link between poverty and burden of disease. Health insurance can positively influence equity through revenue generation, risk pooling, and purchasing. Revenue can be generated through progressive general taxes as well as progressive earmarked taxes for health, payroll taxes, and health insurance premiums.

In addition to reducing the financial risk of out-of-pocket spending on health care, health insurance can expand coverage while maintaining the same budget level by reducing administrative costs and increasing the efficiency of service provision. Governments and regulators can establish accreditation criteria that all health care providers must meet in order to be engaged in the health insurance scheme; such measures can improve quality of care and guarantee the availability of priority services and drugs. Payment mechanisms such as capitation can help to control the cost of primary care while case-based payments can be used to facilitate higher quality health services and provide some cost control. Performance-based payments can also be used to achieve measurable improvement in health results and encourage providers to deliver priority services to low-income populations.

At the most basic level, the key to developing any successful health insurance scheme is to pool the risk of illness or injury over a large, diverse population. By making participation in the health insurance scheme mandatory, the risk is also spread across all citizens regardless of income-level.

¹² Gustafsson-Wright, E. et al. 2010. "Low-Cost Health Insurance Schemes to Protect the Poor in Namibia" in *The Impact of Health Insurance in Low- and Middle-Income Countries*, eds. Escobar, M-L, Griffin, C, and Shaw, R.P. (Washington, DC: Brookings Institute).

3. Rationale for Health Insurance

Universal health coverage ensures all individuals access to essential health services while being protected against the financial hardship often associated with ill health. Out-of-pocket payments force millions of people into poverty every year. Expanding prepayment is the key to universal health coverage. Health insurance schemes can increase financial protection for its members by reducing the need to pay for health services at the point of delivery. Additionally, a health insurance scheme can improve the overall health of its member population as individuals belonging to an insurance scheme are more likely than non-members to access inpatient and outpatient health services.

For the Namibian context, it is important to address why health insurance is necessary to achieve universal coverage when the government provides free access to health care, and to do this, we must revisit the objectives and instruments of health financing policy. Free health services are typically provided through public, donor, and faith-based facilities. However, these services are only accessible to the extent that they are available at these facilities. Health insurance supports and facilitates new institutional arrangements and creates a legal mandate to provide health services in that the beneficiaries are entitled to receive a prescribed set of health services. The institutional arrangements of an insurance scheme ensure long-term sources of funding which could improve administrative processes and generate a results-based payment structure.

Implementing and institutionalizing an insurance function in the overall health system paves the road to achieving universal health coverage and the fundamental objectives of health financing policy - access, equity, financial protection, and quality. To do this, an insurance scheme must ensure that people have access to the services that they need, that the services are of sufficiently good quality to improve the health of users, and that people are protected against catastrophic financial costs. The implementation of a national health insurance scheme is not an end but rather the means to better health.

NHI for the Namibian context could be designed to work efficiently within the overall system while ensuring optimal population and benefits coverage. NHI typically is financed through general taxation and managed by the government. While NHI is usually mandatory for all citizens, cross-subsidization from the wealthy to the poor and government subsidies can reduce the financial burden on low-income individuals. NHI schemes of mature systems, such as the United Kingdom, are often commended for their comprehensive coverage of the population, progressive revenue collection, scope for raising resources, simple mode of governance, and potential for administrative efficiency.¹³

NHI is relatively easy to extend to all citizens, including workers in the informal sector and low-income households, making it one of the most equitable forms of health finance. In addition, the financial burden is spread over the entire population in the form of progressive taxes, value added taxes, or sales taxes. As a single-pool organization, an NHI scheme with a guaranteed benefits package available to all citizens can also benefit from economies of scale, which potentially makes the system more efficient, cost-effective, and easier to administer.

¹³ Gottret and Schieber. 2006. *Health Financing Revisited: A Practitioner's Guide* (Washington DC, World Bank).

In a well-regulated environment, risk-pooling approaches can often be combined to include both public and private actors, encourage healthy competition and provider choice. Private voluntary health insurance (PVHI) can be offered as a supplement to a national health insurance scheme. In the UK, for example, all British citizens have access to health care through its national health insurance scheme; yet, some individuals choose to purchase complementary private insurance to reduce the wait time for health services.

Public private partnerships (PPPs) can be used to leverage the fundraising capabilities of the public sector and mobilize existing private sector resources. The public sector may also provide enabling regulation. PPPs can create more stable risk pools, expand access to health services, and develop and enforce quality and accreditation standards. Finally, private sector insurance experts who are familiar with the market in Namibia can advise on innovations to minimize risk, reduce fraud, and decrease costs across the entire value chain.

Namibia has a reasonably well-developed private health insurance market. Health insurance schemes exist for company-sponsored and individual plans, but individual enrollment is limited. Since 2006, the industry has developed various innovations. For instance, when insurance companies started to offer low-cost insurance products, costs of health care were kept under control by limiting benefits (e.g. through limited inpatient benefits), working through networks of accredited providers, and through innovative provider payment mechanisms such as capitation for primary health care services. Yet, even if employers subsidized part of the low-cost insurance premium, the share of the premium to be paid by the employee remains too high for workers at the bottom of the pay scale. The fact that there are relatively mature private health insurance schemes in Namibia allows the government to focus on covering the uncovered population and also learn from the experience of the private schemes. In particular, the government can focus on making premiums affordable for all beneficiaries, designing an optimum benefits package for specific populations and improve the financial risk protection for the bulk of the population.

The management and financial governance structure of PSEMAS is atypical for an insurance fund in the sense that there is no direct actuarial link between contributions and expenditures leading to questions of the long-term the solvency of the fund. Hence, with the increasing population, increasing demand, and escalating cost of health care, Namibia needs to establish a sustainable health financing system.

Furthermore, the limited revenue-raising capacity particularly from the large number of poor and informal sector; fragmented financing system; the inefficient purchasing arrangements and variable local management capacity particularly at decentralized environments call for designing NHI that will ensure appropriate functioning of the existing financing systems and provide coverage for the uninsured by designing and implementing selected health insurance models.

Objectives of National Health Insurance

The overall objective of designing and implementing NHI is to promote equitable access to sustainable and optimum quality health care and providing increased financial protection for the people of Namibia. To reach the overall objective of UHC, the Government of the Republic of Namibia should design NHI to achieve the following:

- Attain universal health coverage for Namibians.

- Improve linkage and synergy among the existing and new models of health insurance.
- Design and implement a sustainable health insurance that guarantees the delivery of an optimum high-impact affordable package of health services to the entire population.
- Improve financial risk protection in accessing health care services.
- Increase resource mobilization and improved efficiency of the delivery of services.
- Strengthen community participation in the management of health services.
- Establishment of capable organizations to manage NHI and functioning of health institutions to provide adequate and optimum quality of health care.
- Strengthen national capacities to scale-up of health insurance coverage.
- Meaningful collaboration of relevant sectors to support the design and implementation of NHI.
- Develop clear specifications for the operation of the national health insurance scheme in terms of revenue collection, pooling resources, purchasing of services and provision of services.

Any financial or administrative consequences as a result of the services provided under the NHI policy should be dealt with by the organizations involved and no personal administrative involvement by the patient will be required. Implementation of NHI is expected to contribute to the following results for the people of Namibia:

- Improve access and quality of health care services.
- Provide a comprehensive range of health services, which would be free at the point of use to residents of Namibia.
- High coverage of health insurance for both formal and informal sector employees and non-employed groups of Namibia.
- There will be no discrimination based on ability to pay when a resident of Namibia needs health services.
- Well informed citizens who understand and support the NHI scheme.

In the Namibian context, NHI would be a system of health insurance established to ensure universal health coverage to all segments of the population.

4. Options for Health Insurance

While there are many non-financial aspects (e.g. skilled and motivated health care workers, quality services) entailed in achieving UHC, this proposal will focus on the financial perspective. Countries that have come closest to universal coverage often encourage some kind of risk pooling or prepayment approach (WHO, 2010). This infers that payments are made in advance of an illness, pooled in some way, and used to fund health services for everyone who is covered. There are many options of risk pooling—the following are a few of the classic approaches:

- **National health insurance insures a national population for the costs of health care.** The NHI model uses an insurance system as opposed to a budget system, which implies that the pool of state insurance funds, as opposed to the household's personal income, becomes the budget for individuals to service their healthcare needs. NHI is enforced by law and may be administered by the public sector, the private sector, or a combination of both. National health insurance does not equate to government run or government financed health care, but is usually established by national legislation. Irrespective of who contributes, all citizens would be entitled to benefits in an NHI system. The NHI Fund is non-profit and may contract with both public and private sector health providers i.e. it is a multiple delivery system.
- **Bismarck Model/Social Health Insurance (SHI).** The Bismarck SHI model is named after the Prussian Chancellor, Otto von Bismarck, who invented the welfare state. The Bismarck model is rooted in compulsory funding by employers and employees whereby the funds are usually financed through payroll deductions. Those who contribute are entitled to benefits.

A Bismarck SHI scheme can either be made up of multiple risk pools/funds or a single risk pool/fund. The SHI scheme can be funded by a single entity (e.g. the Government) or by multiple entities. It may also consist of a single-purchaser or multiple-purchasers of health care services, where the purchaser of health care services contracts with health care providers to provide health care services to the scheme members. Typically, an SHI scheme contracts with both public and private providers (i.e. a multiple delivery system).

While Namibia is considering an NHI system it is important to draw the key distinction between NHI and SHI. NHI covers the entire population, thereby achieving “universal coverage,” whilst the Bismarck SHI model only covers those in the formal sector who contribute to the SHI Scheme. Given that the Social Security Act of 1994 specifies that the NMBF will cover every employee of every employer, except if he or she is a member of a private medical fund or scheme, the NMBF is essentially envisaged to be a medical fund which, together with the ten existing open and closed medical aid funds in Namibia, will achieve SHI.

- **Beveridge Model.** The Beveridge model is named after William Beveridge, a social reformer who designed Britain's National Health System (NHS). It is funded by general government revenues and covers an entire population. Therefore, it is typically based on taxation and has many public providers. The United Kingdom National Health Service is an example of this model. All citizens/residents are entitled to health care services (irrespective of who is contributing and who is not).

- **Experiences with large scale private insurance:** The main lessons of the role of private health-care funding come from Western Europe and the United States (US). In the US, spending on health reached \$2 - 4 trillion in 2008, equivalent to 17% of GDP. However, an estimated 47 million citizens have no health coverage and another 25- 45 million are covered by insurance that is inadequate. The level of private spending on health care has risen in western European countries and in the US, leading to concern about its cost and sustainability.

In these countries, the primary channels for private spending on health care are private health insurance policies and cost-sharing schemes in public health systems. Private sources of health care funding are often regressive and present financial barriers to access. Private insurance contributes little to efforts to contain costs and may actually encourage cost inflation. Supplementary private insurance increases inequalities of access, particularly where there are no clear boundaries between public and private health care provision.

To confront these issues, a major health care reform is underway in the US. The new legislation makes sweeping changes to existing laws governing employer-sponsored group health plans, individual health coverage, and governmental health programs. Starting in 2014, the new health care reform legislation makes it illegal for insurance companies to discriminate against people with pre-existing conditions, ensuring that families purchasing their own health insurance receive a package of essential benefits similar to what private insurers offer.

Private health insurers lack efficiency incentives and tend to incur higher administrative costs than statutory health insurance. Private health insurance should be regulated to ensure access and consumer protection. Publicly-funded systems are generally more successful in controlling cost inflation than mainly privately-funded systems.

Guiding Principles and Enabling Factors

Before embarking on a full-blown reform of the health financing system, it is important to define some guiding principles that should underpin critical decisions regarding the way forward. The following principles will guide the design and implementation of NHI in Namibia.

- NHI will be designed and implemented with the overarching objective of achieving universal health coverage for all segments of the Namibian population.
- Underlying demographics, epidemiology, and economic situations determine underlying 'needs' and ability to meet those needs.
- Financing changes must be coordinated with all other health systems reform efforts
- Design and implementation of NHI will as much as possible be based on evidence and the process will be carefully managed.
- Collaborate with all stakeholders and development partners at all levels on formulating and implementing NHI.
- Avoid trying to 'import' models – learn from their experience and make best practices context specific, i.e. NHI must be tailored to Namibia's country socioeconomic, political, and geographic circumstances.

There are 15 enabling factors for health financing reforms grouped into three broad categories.¹⁴ These are:

Institutional and Societal Factors

- Strong and sustained economic growth
- Long term political stability and sustained political commitment
- Strong institutional and policy environment
- High levels of population education

Policy Factors

- Commitment to equity and solidarity
- Health coverage and financing mandates
- Financial resource committed to health
- Consolidation of risk pools
- Limits to decentralization
- Primary care focus

Implementation factors

- Coverage changes accompanied by carefully sequenced health service delivery and provider payment reform
- Good information systems and evidence based decisions
- Strong stakeholders support
- Efficiency gains and co-payments used as financing mechanisms
- Flexibility and midcourse corrections.

The current situation in Namibia demonstrates that some of the enabling factors exist while some do not. For instance, strong and sustained economic growth, long term political stability and sustained political commitment are among enabling factors that prevail. There are also factors such as good HIS and evidence based decision-making that are relatively weak and need strengthening to improve the likelihood of success in designing and implementing NHI.

¹⁴ Gottret, Schiber, and Waters 2008, Health Financing Revisited, The World Bank

5. Implementation of a National Health Insurance Scheme

Legal and Regulatory Environment

The current mandate of the Social Security Commission (SSC) is limited to establishing the National Medical Benefit Fund (NMBF), which shall provide “for the payment of medical benefits to employees.” In accordance with the Social Protection Floor (SPF),¹⁵ a United Nations initiative led by the International Labor Organization (ILO) and WHO, emphasis should be placed on the “promotion of access to essential services and social transfers for the poor and vulnerable inclusive of health services.” The regulatory provision for the NMBF and promulgation of the SPF gave rise to the idea that the NMBF should be implemented in the form of a NHI. While initially conceived as a form of social health insurance, the NMBF could potentially serve as a subset of a greater National Health Insurance Scheme (NHIS). During the September 2011 Health Insurance Workshop, two key issues emerged: first, every effort should be made to examine the overall picture of socio-economic status, health systems and the current health insurance market of Namibia in exploring an NHIS; and second, an NHIS that will ensure universal coverage should be designed by incorporating the existing insurance schemes in Namibia through the engagement of relevant stakeholders.

The Ministry of Health and Social Services (MoHSS) has a mandate on Social Protection, specifically, addressing the social needs of vulnerable groups such as poor and marginalized groups. The MoHSS mandate further covers engaging non-profit welfare organizations in dealing with social welfare for marginalized groups. In that the SPF emphasizes the promotion of access to essential services and social transfers for these populations, it was determined that the MoHSS has the mandate for the achievement of UHC in Namibia.

The Roadmap for the Design and Implementation of National Health Insurance in Namibia: A Draft for Discussion (Jan 2012, unpublished) prepared by the Health Systems 20/20 project and the SSC examines health financing and the proposed solution (i.e. NHI) rather than a narrow focus on NMBF and reviews the mechanisms and requirements for the implementation of NHI. In outlining all of the components to be considered in the design of a NHIS, the roadmap will allow policy makers to make informed decisions about the way forward for the achievement of UHC and identify the most suitable custodian for NHI. It is critical that this decision be made in a timely manner to allow for NHI to move forward.

The Role of HIFTAC and the Proposed National Health Insurance Secretariat

At the September 2011 Health Insurance Workshop, a proposal and draft terms of reference for the establishment of a National Health Insurance and Financing Technical Advisory Committee (HIFTAC) were presented and principally endorsed by the workshop participants. The structure of the HIFTAC, as defined in the initial terms of reference presented, is such that the HIFTAC reported to the SSC board due to the SSC’s mandate for the establishment of the NMBF. After further

¹⁵ The Social Protection Floor is a global social policy approach promoting integrated strategies for providing access to essential social services and income security for all. Recognizing the importance of ensuring social protection for all, the United Nations System Chief Executives Board for Coordination (UNCEB) adopted, in April 2009, the Social Protection Floor initiative. This initiative is co-led by the International Labour Office and the World Health Organization. (Social Protection Floor Advisory Group, International Labour Organization, <http://www.ilo.org/public/english/protection/spfag/index.htm>).

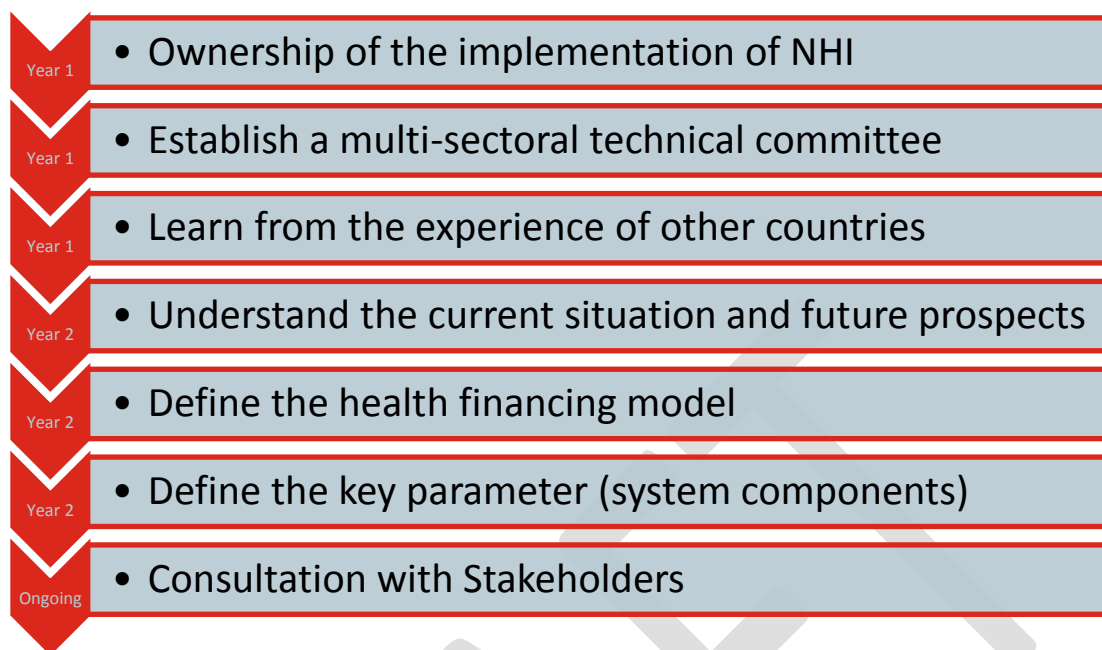
discussions on the objectives and scope of the proposed NHIS, it was proposed that the HIFTAC might be better placed under MoHSS due to its broader mission for the achievement of UHC in Namibia. The objective of HIFTAC is to provide advice and guidance to the MoHSS on the development of a NHIS in Namibia with a focus on evidence and potential models. HIFTAC will provide technical recommendations on a way forward with achieving Universal Coverage in Namibia and also delve into broader health financing issues as needed. These may include achieving the necessary preconditions for implementation of health insurance, improved facility autonomy and governance, robust health management information system and standardization of quality of health care. Subsequently, a working group was established under the HIFTAC which aims to provide administrative and technical support to the full HIFTAC and will work to operationalize the agendas and decisions made by the HIFTAC.

HIFTAC members are drawn from a variety of institutions and represent a broad range of relevant disciplines. The Minister of each proposed Government Ministry and in the case of other bodies, the head of the institution/body shall nominate one person as a representative on this committee. The exception shall be the Minister of Health and Social Services and SSC Board which shall each have the prerogative to nominate two persons. Because the committee is mostly comprised of representatives who are in full-time employment they will not have sufficient time to operationalize most of the key activities and decisions to ensure the establishment of NHI. It was therefore recommended that a formal Secretariat be created with full-time staff to manage the day to day activities of establishing NHI.

Implementation Process

Taking the current context on Namibia into account, there are two major phases of developing and implementing NHI. The two broad phases are a preparatory phase and an implementation phase. It is important to carefully review each step, prioritize, reorganize, and manage the design and implementation throughout the reform process. Further descriptions of the steps under each phase can be found in Annex A.

PREPARATORY PHASE



IMPLEMENTATION PHASE



Implementation Timeline

The progress made to date by the HIFTAC includes a majority of the activities under the “Multi-sectoral Technical Committee” step in the Preparatory Phase.

The anticipated timeline for completion is two years for the preparatory phase and two years for the implementation phase. Therefore, if the Secretariat were to be in place for the full implementation of NHI, it is recommended that the Secretariat be established for at least four to five years.

6. Management of a National Health Insurance Scheme

Role of the MoHSS

The MoHSS has the mandate for achieving UHC in Namibia, recognizing the health inequities in accessing health services and promoting health as a basic right of all the citizens. The MoHSS leads a participatory constitutional process for the expansion of a model of health insurance that guarantees access to essential services and improves the efficient use of resources in the health sector while exercising the steering role in the health sector.

The National Health Insurance emphasizes the promotion of access to essential services and social transfers to the most vulnerable populations. The MoHSS has a mandate on Social Protection, specifically, addressing the social needs of vulnerable groups such as poor and marginalized groups. The MoHSS mandate further covers engaging non-profit welfare organizations in dealing with marginalized groups. NHIS that will ensure universal coverage should be designed by incorporating the existing insurance schemes in Namibia through the engagement of relevant stakeholders

Role of the SSC

The Social Security Commission (SSC) has the mandate of establishing the National Medical Benefit Fund (NMBF) to provide payments of medical benefits to employees. However, the SSC is uniquely placed to providing technical and policy assistance for the constitutive process and a regulatory role.

Being in charge of the NMBF, the Commission can provide technical assistance to define the depth and breadth of a national benefit package of health services, determine its cost as well as its long term financial requirements.

The commission also would be able to support the estimation of the level of subsidies required to cover the formal as well as the informal sector. Critical to this process is the analysis of cross-subsidization to ensure sustainable ways of providing subsidies for low-income groups.

The SSC could be responsible for developing regulations, determining contributions and subsidies. Also the commission could have an important role in ensuring that private voluntary health insurance (PVHI) schemes adapt their products to complement NHIS. The health care reform in Colombia is an example where the country was able to extend SHI by subsidizing premiums for the poor through an equity fund financed by general tax revenues and payroll taxes.

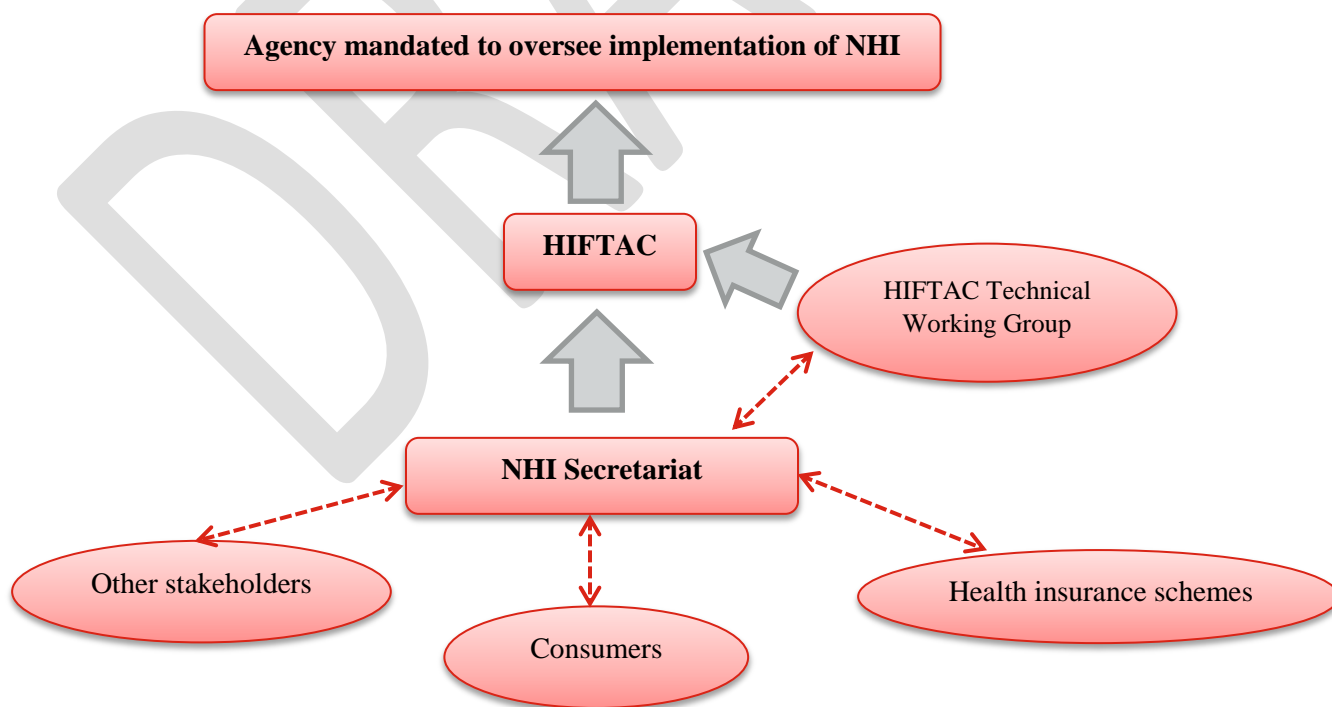
National Health Insurance Secretariat

The Secretariat will be guided by the HIFTAC and should take the lead in producing a clear plan of action with detailed activities, time frames, responsible institutions, budget, and monitoring framework of both the preparatory and implementation phases. The plan will then be reviewed by HIFTAC and relevant stakeholders and approved. Subsequently, this Secretariat will follow up on the implementation of the plan using agreed measures.

It is recommended that the Secretariat be staffed with at least a Project Manager, Health Economist, a Public Health Officer, and a Logistics Support Officer. Some of the key activities of this Secretariat team would include:

- Coordinate HIFTAC meetings, agendas, timelines, and outcomes

- Help identify through consultations with stakeholders, including the HIFTAC, needed studies/ analyses as a precondition for establishment of NHIS.
- Support the HIFTAC in monitoring proper implementation of those studies.
- Review the recommendations from any studies and assess their applicability to the Namibian context and/or provide alternatives.
- Make technical recommendations (incorporating input of the HIFTAC) to the MoHSS and SSC on the way forward in the implementation of NHIS and the NMBF.
- Serve as key liaison between the MoHSS, SSC and other bodies dealing with health insurance in Namibia.
- Impart knowledge and skills to MoHSS and SSC on national and social health insurance.
- Assist in the development of the roadmap that will result in Namibia having a National Health Insurance Scheme. This includes assessment of capacity gaps, developing strategy to fill the gaps and support implementation and monitoring this strategy.
- Organize and host workshops with key stakeholders in Namibia on national health insurance issues.
- Identify and lead peer-learning visits to countries from which Namibian can gain and share experience with regards to national health insurance.



Key Personnel

There are four proposed key personnel to carry out the day-to-day activities of the National Health Insurance Secretariat. These include:

- A Project Manager
- A Health Economist
- A Public Health Officer, and
- A Logistics Support Officer

The **Project Manager** will provide the general oversight and coordination for the Secretariat, including management of budgets, staff, and activity implementation. This individual will ensure that that Secretariat is responding to and meeting the needs of the HIFTAC and serve as the principal point of contact with all Government Ministries and stakeholders.

The **Health Economist** will serve as the principal health care financing advisor to the HIFTAC. Through consultations with key stakeholders, the health economist will identify and implement studies and analysis critical for the design and establishment of a National Health Insurance Scheme. This individual will make technical recommendations to the agency with the mandate to implement a National Health Insurance Scheme and serve as that agency's liaison to other agencies working with social health insurance.

The **Public Health Officer** will serve as the principal public health advisor to the HIFTAC. This individual will be responsible for ensuring that the proposed National Health Insurance Scheme meets the promotive, preventive, curative, and rehabilitative health needs of the Namibian population. Particular attention will be made to ensuring access to health services for underserved populations.

The **Logistics Support Officer** will provide timely, efficient, and high quality support to the Secretariat during implementation of its activities.

Proposed Budget

A budget has been drafted to estimate the costs that would be incurred over the next five years for the preparation and implementation phases for NHI. The detailed budget including the underlying assumptions is included in Annex B.

Description	Year 1	Year 2	Year 3	Year 4	Year 5	Total
	N\$	N\$	N\$	N\$	N\$	N\$
1. Establish NHI Secretariat	2,920,036.91	2,785,000.00	2,785,000.00	2,785,000.00	-	11,275,036.91
2. Establish multi-sectoral technical committee (HIFTAC)	65,200.00	65,200.00	65,200.00	65,200.00	65,200.00	326,000.00
3. Learn from experiences from other countries	527,320.00	-	-	-	-	527,320.00
4. Understand current situation and future prospects	-	1,365,224.00	-	-	-	1,365,224.00
5. Define the health financing model	-	508,602.00	-	-	-	508,602.00
6. Define the key parameters	-	160,912.00	-	-	-	160,912.00
7. Consultations with stakeholders	83,188.00	83,188.00	83,188.00	83,188.00	83,188.00	415,940.00
8. Enact laws to provide legal sponsorship	-	-	375,800.00	-	-	375,800.00
9. Setting up administrative structures	-	-	-	6,458,333.33	5,590,000.00	12,048,333.33
10. Develop standards and detailed operational manuals	-	-	-	402,214.00	-	402,214.00
11. Awareness campaigns and communication	-	-	-	528,600.00	328,600.00	857,200.00
12. Effective collaboration with key sectors	-	-	-	750,800.00	300,800.00	1,051,600.00
13. Procurement of ICT Equipment and Software	1,830,318.83	-	-	-	-	1,830,318.83
GRAND TOTAL in N\$:	5,426,063.74	4,968,126.00	3,309,188.00	11,073,335.33	6,367,788.00	31,144,501.07
GRAND TOTAL in USD:	678,257.97	621,015.75	413,648.50	1,384,166.92	795,973.50	4,755,959.38

An exchange rate of N\$8.00 to USD1.00 was used for the preparation of this budget.

7. Conclusion and Next Steps

The extensive income inequalities in Namibia and high number of people living in poverty place increased pressure on the Government of the Republic of Namibia to address the resulting health inequalities in the country and barriers to access of health care. Specifically, the Government needs to identify means of providing quality health care to its entire population and achieving UHC in a sustainable manner. Due to the link between poverty and disease burden, it is important for the Government to address issues relating to access and equity in the provision of health care. NHI is being recommended as a possible solution to improving access and equity while also being a sustainable means of achieving UHC.

The MoHSS has the mandate of addressing the social needs of vulnerable groups such as poor and vulnerable groups, which includes the promotion of access to essential services and social transfers for these populations. As a result, it was determined that within the Namibia Government the MoHSS should also be mandated with the achievement of UHC. At the same time, the SSC has a mandate for the establishment of the NMBF, which as a form of SHI, could potentially serve as a subset of a greater NHI scheme. The fact that Namibia has a reasonably well-developed private health insurance market would allow the Namibia Government to focus on covering the population left uncovered by the NMBF and private health insurance. In particular, the government can focus on making premiums affordable, designing an optimum benefits package for specific populations and improve the financial risk protection for the bulk of the population. It is therefore recommended that MoHSS works towards the achievement of UHC by designing a NHI scheme that compliments the coverage of the proposed NMBF and the private health insurance schemes.

Next Steps:

1. Agreement needs to be reached on the organization/institution best placed to lead the implementation of NHI.
2. The HIFTAC should be fully constituted, and
3. The process of recruitment for and establishment of the NHI Secretariat should be initiated.

ANNEX A. Phases of Implementation

Preparatory Phase

This section presents key activities to be implemented during the preparatory phase of designing and implementing the NHI.

Ensuring Fulltime Ownership

Description: The process of developing NHI is complex and time taking. An ad-hoc team, such as the Health Insurance and Finance Technical Advisory Committee (“HIFTAC”) that was already established in Namibia, is very important to bring the perspectives of diverse organizations into the design and implementation of NHI. However, each member of HIFTAC has his/her own work with his/her respective organization. Hence, a Secretariat with a team of experts who are charged with managing the day to day activities of establishing NHI needs to be in place and it is proposed that this Secretariat is housed within the Ministry of Health and Social Services as the Ministry is more directly mandated with the achievement of UHC than the SSC. This Secretariat can be strengthened by seconding technical assistants of various disciplines such as health economist, public health officer, logistician etc. and should be guided by the HIFTAC. This Secretariat should take the lead in producing a clear plan of action with detailed activities, timeframe, responsible institutions, budget, and monitoring framework of both the preparatory and implementation phases. The plan will then be reviewed by relevant stakeholders and approved. Subsequently, this Secretariat will follow up on the implementation of the plan using agreed measures.

Objectives: to establish a formal unit in the government structure to handle the day to day work of designing, consulting, managing and monitoring the reform.

Key activities: the following key activities will be implemented towards establishing an NHI coordination team/unit (*this is just one option of establishing the team*).

1. Pool staff from SSC, MOHSS, MLSW (preferred background on M&E, organizational and institutional development, and administrator).
2. Hire a health economist.
3. Provide office within the Ministry of Health and Social Services.
4. Provide job description to the team.
5. Develop a plan of action for the whole exercise.
6. Monitor implementation using agreed measures.

Strengthen the multisectoral technical committee (HIFTAC)

Description: Establishment of a health insurance system knocks on the door of multiple sectors (both within and outside the government). These sectors have diverse nature and interests that could either hinder or facilitate the reform. Hence, it is important to bringing together these stakeholders with the view of involving them from the very inception of the NHI and avoid any surprises late in the design or implementation phases.

Objectives: Establish a functional multi-sectorial ad-hoc committee with the aim of ensuring buy-in and ownership via incorporating the perspective of various stakeholders in the course of the design and implementation of NHI.

Key activities: the following key activities will be implemented towards establishing an NHI coordination team (*most of these activities have already been implemented*).

1. Get the draft TOR for the HIFTAC TWG approved by the Ministry of Health and Social Services.
2. Broaden the membership of the Committee.
3. Build the capacity of the Committee on the basic concept of NHI and context specific issues relevant to Namibia.
4. Provide the appropriate administrative, technical and financial support to the committee to enable it discharge its responsibilities.

Learn from Experience of Other Countries

Description: Over the last several decades, various countries across different regions of the world have been trying to implement reforms with the intention of establishing the right health care financing mechanisms to ensure optimum benefit and population coverage in a sustainable manner. These countries have passed through various challenges and accumulated a wealth of experience in the course of those reforms. Lessons could be learnt from the experience of those countries in order to avoid common mistakes and replicate best practices that fit into Namibia's context.

One way of facilitating this is by conducting a study tour by HIFTAC and critical mass of technical and policy makers. Countries for the study tour could be selected based on specific criteria to ensure relevance of lessons to Namibian context. Some of the criteria include:

- Success in achieving high population coverage;
- Implementation of various health insurance models (social, community, private etc.)
- Representation of various regions of world (Africa, Asia and Latin America)
- Mix of Middle and Low income countries;
- Established synergy of health insurance with other health system components.

Objectives: to ensure transfer of knowledge and skills pertaining to the design and implementation of NHI from relevant countries to Namibia.

Key activities: the following key activities will be implemented towards learning from the experience of other countries.

1. Develop synopsis of health insurance in selected countries for HIFTAC to choose from.
2. HIFTAC selects countries to be visited.
3. Develop a comprehensive checklist that will enable systematic capture of experience from those countries.
4. Conduct study tours and produce a consolidated report of experience.
5. Share the lessons with the rest of key stakeholders in Namibia.
6. Use the lessons to shape the design and implementation of NHI in Namibia.

Understand the Current Situation and Future Prospects

Description: Designing and implementing NHI is a complex and resource intensive exercise. An NHI should be sustainable, affordable and guarantee the delivery of optimum benefit package to the population while ensuring equity. To guarantee this, a comprehensive study on effective

operationalization of NHI is necessary along with appropriate phasing and sincere implementation. A systematic assessment of the current situation should be conducted using the conventional analytic framework which integrates the various health financing sub-functions and policies. The framework includes revenue collection, pooling of resources, purchasing of services and provision of services.

Labor and financial market structure is one of the key parameters to examine. The relative proportion of employed and unemployed, income distribution, current level of taxation, payroll deduction, and prospect of economic growth and feasibility of levying further health insurance taxes are key factors that need to be made clear. A study of the labor structure could also inform availability of groups such as bus, truck or taxi drivers and conductors, fishermen, village agricultural cooperatives etc. that would facilitate premium collection. In a country such as Namibia that has already introduced public and private health insurance, it is important to look into the depth and breadth of the existing coverage, the gap in coverage and various options of fitting the existing systems together in order to ensure universal coverage. To this end, the revenue collection, risk pooling, and purchasing arrangements of the current system needs to be analyzed and help as an input to the new system.

Any of the health insurance models works better in an environment where the health care facilities are accessible and have the capacity to deliver the package of services defined in the benefits package for the insured people. Hence, the health service delivery capacity is a critical factor that needs to be assessed.

In summary, some of the studies include actuarial study, service availability and facility readiness study, unit cost of health services, study of provider payment mechanism options, willingness and ability to pay, capacity of various institution that get involved in the implementation of NHI, etc.

Objectives: agree on a plan and resources to identify and conduct studies to inform the current status and future prospects of key parameters for the design and implementation of NHI with the view to:

1. Set baseline information on the various mixes of population, health status, available services and impact of the existing financing mechanisms using the research report for the NMBF as source for most of this information.
2. Understand the magnitude and impacts of new health care financing reform, and characteristics of the affected group.
3. Understand potential risks and think through mitigation measures to minimize the impact.
4. Understand alternative options; decide on the best alternative with utmost benefits and least costs.

Key activities: the following key activities will be implemented towards identifying and conducting essential studies.

1. Identify key parameters that should be defined to design NHI.
2. Review literature to find recent and relevant information on the parameters.
3. Identify the gap in information.
4. Conduct expert consultation to come up with the easiest, cheaper method of conducting the studies to get the results in the shortest possible time.
5. Mobilize the necessary resources for the studies.
6. Conduct the studies and pay attention to quality assurance while doing so.
7. Use the results to inform and influence decisions on the design and implementation of NHI

Define Health Financing Model

Description: Health financing involves three basic functions: revenue collection, pooling of resources and purchasing of services. Revenue collection deals with identifying the sources, defining how it is collected and collecting resources. Pooling deals with unpredictability of illness & inability of individuals to mobilize resources hence, need to pool risk across individuals and over time. Purchasing is transfer of pooled resources to health service providers so that appropriate and efficient services are made available to the population.

Defining these three functions in a certain context entails examining the complex interaction of various stakeholders both within and outside the health sector. The way these functions are organized has also an important bearing on amount of funds made available; proportion of population covered; depth and breadth of benefits package; equity of financing and benefits; efficiency and sustainability of the system.

Basic health financing functions are generally embodied in the following models¹⁶:

1. **National Health Service:** compulsory universal coverage, national general revenue financing, and a national ownership of health sector inputs. Revenues are generated from the indirect contribution of the population as general tax. A tax-funded health system needs a robust tax base and strong institutional capacity to effectively manage taxes.
2. **Social Insurance:** compulsory universal (employment group-targeted) coverage under a social security (publicly mandated) system financed by employee and employer contribution to non-profit insurance funds with public and private ownership of sector inputs. Social health insurance can provide additional source of funding for health and could help to maintain a degree of independence of funding, could help improve health service coverage in countries where labor markets is growing rapidly.
3. **Community based health insurance schemes:** While SHIs are for the formal sector, community based health insurance schemes (CBHIs) are widely practiced for informal and rural sectors in developing countries. CBHIs are insurance schemes characterized by voluntary membership, pre-payment of contribution into a fund and entitlement to specified benefits, nonprofit character, important role of the community in the, design and running of the scheme, institutional relationship to one or several health care providers. CBHI schemes need to be subsidized in order to be financially sustainable and improve benefit coverage, capacity of management needs to be strengthened and administrative cost needs to be reduced so that funds will be used as much as possible to purchase services for the community.
4. **Private Insurance:** employer-based or individual purchase of private health insurance and private ownership of health sector inputs. Development and expansion of the health insurance scheme should be seen in the context of liberalization of trade including opening markets for the private sector. Private health insurance schemes needed to be regulated to ensure the basic principles of solidarity, cross-subsidization and control of exclusion.

In defining the right model of financing, some of the major factors that need to be considered include alignment with the health policy objective; impact on health sector; existing health infrastructure; equity considerations; stakeholders' interests; history, culture and social values of the country;

¹⁶ The World Bank 2006; Health Financing Revisited, A practitioner's Guide. Washington DC

administrative capacity of the country; earnings, taxation, and contribution base; and labor market structure.

In Namibia, about 60% of the population operates in informal sector employment, in particular in subsistence agriculture. Agriculture and fishing employees make up 29.9% of total employment. About half of Namibia's people are unemployed; unemployment rate was estimated at 51.2% in 2008. The unemployment rate is higher in rural areas (64.9%) than in urban areas (36.4%). Besides, about 6% of population pays personal income tax. These have a significant impact on the model of health insurance to be designed and implemented.

Furthermore, Namibia has a mix of government (PSEMAS) and private models of financing with varying levels of coverage. The population is also composed a mix of formal sector, informal sector; and unemployed people. In Namibia, there is a need to a design specific model of insurance to address the needs of these fragmented groups in the population and any underlying inequities.

Objectives: to make evidence based choices of the appropriate health insurance models to ensure achievement of universal health coverage for all Namibians.

Key activities: the following key activities will be implemented to achieve this objective.

1. Identify the level of population coverage under the current system.
2. Identify the depth and breadth of benefits coverage under the current system.
3. Identify gaps in population and benefits coverage for the population.
4. Consider the key parameters defined in the above-mentioned studies.
5. Consider lessons learnt from study tours.
6. List various mix of options with pros and cons in Namibian context.
7. Undertake option appraisal.
8. Consult with key stakeholders.
9. Secure policy decision on the preferred options.

Define Key Parameters (system components) for the selected insurance model

Description: this section provides the main parameters that need to be defined, key characteristics and factors that need to be considered, the objective of the whole exercise, and stepwise actions that need to be taken to this end.

Population Coverage and Membership: Population coverage covers issues such as solidarity across the population; risk equalization and cross subsidization; arrangement for social assistance to cover vulnerable populations (young and old aged, disabled, pregnant women); etc. A number of factors influence which segment of the population should be covered in health insurance. There could be political and historical factors that dictate the inclusion or exclusion of population groups. Technical factors also play significant role by answering the kind of risk mix needed to ensure a functioning health insurance system. Many of the technical factors overlap with feasibility which is informed by the analysis of the existing situation that should be conducted prior to this step.

Another key aspect of the design is defining membership. Membership could either be compulsory or voluntary. For instance, compulsory membership in SHI entails membership of an individual or groups of individuals, and/or their immediate households and other dependents, on a mandatory basis.

Offering voluntary membership may entice certain group of population particularly when they are dissatisfied with the existing quality of care. Many of the CBHI schemes for informal sector population in developing countries also provide voluntary membership. However, voluntary membership is associated with adverse selection unless mitigation measures are embedded in the design.

Currently, 51% of the formally employed Namibians are insured which equates to 16-18% of the population. Only about 12% of the population is covered by PSEMAS; allowing them to access to private health service system. Private insurance companies provide health insurance policies for private sector employees. This information needs to feed into the decision of population coverage. The model of health insurance to be adopted largely defines whether membership should be compulsory or voluntary.

Benefits coverage: Benefits coverage implies the range of specific services that can be covered under a health insurance scheme. There will be a difficult tradeoff between breadth and depth of coverage, which has important implications for equity, financial protection, health outcomes and costs. In principle, the benefit package should cover diseases of public health importance that cannot be accessed otherwise. Benefits coverage could vary between different populations groups of socio-economic status, among various geographic regions, technical feasibility and political priority. In general the following are issues that need to be considered in determining benefits coverage:

- the pattern, magnitude and sources of public health problems;
- developing agreed criteria for defining benefits package.
- mechanisms of dealing with services not included in the packages.
- determining the cost of services and availability of financial resources;
- availability of capable health infrastructure and quality of services;
- rate of health care utilization by the entitled population;
- diversity of labor and financial structure of the beneficiaries;
- the mandate of various social security structures.

Furthermore, in deciding what services to include, attention is usually focused on attempts to balance technical approaches for population health needs assessment, technology assessment, and the cost effectiveness of interventions.

Financing: Health systems can meet clinical and social responsibilities only if they are able to raise adequate finance. Financing of NHI in Namibia answers three main questions: what are the sources of finance? What are the methods of financing? And what are their impacts and incentives? Availability of adequate funds is the backbone of a sustainable health insurance system that ensures optimum and sustainable population and benefits coverage. Source of funding could be:

- government subsidies;
- contribution from members,
- co-payments;
- donations,
- consumer taxes (e.g. sin taxes);
- innovative means (e.g. levy on airline tickets);
- return on investment;

- others (fines for late payment, circumvention fees etc).

Each of these sources has different implications on the design of health insurance. They also have different political objectives and impact on service providers, consumers and regulators. In contributory regimes, contribution should be based on ability to pay (based on economic means) and not related to health risks of individuals, households or employment groups. Collection of revenue needs establishment of appropriate mechanisms for collecting regular contributions. Systems that rely mainly on public funding tend to do better at attaining objectives such as financial protection, equity in finance, equity in utilization. Hence, the fiscal context becomes more important because the more money the government has, the more it can spend.

Health financing in Namibia is mainly tax-based. Health care spending as a percentage of total government spending is 13.5% - the highest in the region, but still short of the Abuja Target of 15%. User charges (registration fee) in the public sector are in place. International partners provide support targeting special programs. Their contribution was 23% in 2007. The private sector contribution is 25%. These facts need to be considered in deciding the source and level of financing of NHI.

Provider Payment Mechanism: Establishment of insurance system (except for National Health Service model) usually leads to separation of provider and purchaser of health services. There are different provider payment mechanisms with different effects on quality of services, cost implications and administrative arrangements. Hence, purchasing and contracting arrangements must be technically and allocatively efficient and ensure sustainability of the system. The major provider payment mechanisms include fee for service, capitation, global budget and Diagnosis Related Groups (DRG). In a certain insurance model, one or combination of provider payment mechanism could be applied.

In general, providers are interested to maximize their income depending on the payment system. They try to achieve this through: attracting many patients, increasing repetition of visits, providing as many treatments as possible, discouraging financially unattractive patients. Hence, some of the major principles underpinning selection of provider payment mechanism include:

- providing adequate resources and motivation for providers to produce services of optimum quality;
- Reduce unnecessary wastage of resources.

Issues that need to be considered in defining the provider payment mechanism include defining the services to be covered; establishing the unit cost and efficient level of to cover costs; set payment levels; assess the cost of operations (administration); and choose payment methods.

Mode of Implementation of NHI: Depending on the choice of health insurance model a country can decide to start with pilot tests, evaluation of pilot tests and full scale implementation by incorporating the lessons learnt from the pilots. For instance, experience from countries with high coverage of SHI schemes indicates that there had been a gradual development over decades from single-funded SHI to multiple-funded SHI later, and national health insurance.

If Namibia decides to expand SHI to the whole formal sector, it needs to lay down the strategic framework on how it would go from the SHI stage to NHI within a specified time frame. The strategy

could also indicate how the schemes for the informal sector integrate into that of the formal sector over a long period of time. Given Namibia's high proportion of population working in the informal sector, nationally organized gradual expansion of social health insurance to the self-employed and non-formal sector is crucial for the achievement of universal coverage.

Objective:-define key parameters underpinning the design and scaling up of the insurance model selected in Namibia.

Key activities: the following key activities will be implemented towards defining the key parameters.

1. Technical team lists the key parameters.
2. Compile information on the current status and future prospects of these parameters from the various studies.
3. Conduct option appraisal.
4. Conduct wider stakeholder consultation on the various options.
5. Incorporate the feedback from stakeholders, feed the parameters into the selected health insurance model, and rank the options.

Consultation with Stakeholders

Description: consultation of stakeholders at key turning point of health insurance design is critical in order to ensure buy-in. Stakeholders include the government ministries, service providers, regulators of health service, civil society organizations, existing health insurance providers, beneficiary groups and development partners. The policy stakeholders, such as parliamentarians and cabinet also need to understand the vision and mission of the whole exercise in order to develop appropriate policies and strategies to successfully implement the proposed mix of health insurance models.

Objectives: ensure buy-in and support of the proposed health financing models from key stakeholders through rigorous consultative process.

Key activities: the following key activities will be implemented towards rigorous consultative process.

1. Prioritize and rank issues for stakeholder consultation.
2. Identify and map stakeholders.
3. Tailor issues and consultative process to the interest and influence of stakeholders (identified through prior stakeholder mapping).
4. Identify champions to lead consultative process.
5. Conduct consultations.
6. Document and use the feedback to improve the proposed models and system components proposed.

Implementation Phase

Following the completion of preparatory phase, a number of key actions need to be implemented. Some of these include providing legal coverage to the system, developing detailed implementation arrangements, effective communication to raise the awareness of all stakeholders, putting in place administrative arrangement and support structures. This section provides objectives and key activities related to these issues.

Enact laws to Provide Legal Sponsorship for Implementation

Description: Once the health insurance model and the components of the system have been well consulted and agreed, it needs a legal backing in order to create a conducive environment for implementation. The type of legal instrument and the political authority that endorses it varies from country to country. For instance the legal document could be a proclamation, legislation, a bill etc. Authority in charge of providing the legal backing could also be the parliament or the cabinet. For instance in Ethiopia, health insurance proclamation was passed by the parliament, legislation by the cabinet and directives are passed by the Health Insurance Agency itself. Therefore, depending on the issues identified, Namibia needs to decide on the various types of legal instruments that need to be passed and respective responsible authorities. Namibia should also decide whether one or multiple legal instruments are needed for the various insurance models agreed up on based on its local context.

Some of the issues that need to be addressed in legal instruments include:

1. Who manages funds (and the insurance schemes in general) and the various governance structures.
2. Target groups/target population to be covered by specific insurance models (formal, informal etc);
3. General description of the benefits package (out-patient services, in-patient services, drugs, non-medical services portability, etc)
4. Mode of enrollment (mandatory vs voluntary)
5. Membership (Eligibility criteria, registration, renewal, unit of membership (coverage of dependents))
6. Finance (subsidy, auditing, etc)
7. Premium (method of collection, period of collection, responsible body for collection, fine for delay)
8. Service Provision (Accreditation, ownership)
9. Providers' payment mechanism (period of reimbursement, fine for delay)
10. Risk mitigation (against adverse selection, moral hazard, and cost escalation)
11. Claims management.

As indicated in the introduction section of this document, various mandates of social security are currently scattered across a wide range of organizations. The current mandate of SSC is also limited to establishment of NMBF. Hence, this step is crucial to review the existing legal mandates, fill the gaps and consolidate. This step, therefore, clarifies which institution is responsible for managing which model of health insurance, how these can be harmonized in terms of budget subsidies, benefits package, an payment mechanisms so that the overall system will be efficient, effective, sustainable and equitable.

Objectives: ensure legal backing of the selected health insurance models for Namibia in order to create conducive environment for effective implementation.

Key activities: the following key activities will be implemented towards development and endorsement of legal instruments for various health insurance models in Namibia.

- Establish a temporary Secretariat under HIFTAC.
- Provide orientation and training to the committee on health financing/insurance and the progress so far.
- The Committee reviews the existing laws and identifies gaps.

- The Committee decides on the issues, types of legal instruments required, necessary consultative process and sequence of submission to the relevant authorities.
- A plan of action will be developed and agreed between HIFTAC and the Legislative sub Committee.
- Legal instruments will be drafted, consulted, submitted to relevant authorities and endorsed as per the agreed plan.

Setting up the Administrative Structures

Description: The scope and complexity of this task depends on the type of health insurance model selected (SHI, CBHI, etc.), the nature of decisions regarding the scaling up (i.e. pilot versus full scale implementation), the agreed level of decentralization of administrative roles, etc.

Setting up the administrative structure ranges from establishing the central body accountable for managing NHI to setting up the health insurance administration schemes. It also includes establishing governance structures for the schemes, defining specific population, selecting service providers, signing contractual agreement with providers, setting up internal and external monitoring system, establishing relations with key actors, commencing effective communication etc. As part of this exercise, it is important to focus on minimizing duplications of functional responsibility among various actors. The focus should not only be reducing costs but also maximizing cost-effectiveness of the administrative functions in terms of impact on the policy objective.

Objectives: to put in place the necessary organizational structure and translate standard procedures detailed in operational manuals into action.

Key activities: the following key activities will be implemented towards setting the administrative structures.

1. Designate a responsible office/s for managing and overseeing the various health insurance models (as part of enacting the law) at national level.
2. Recruit staff and provide the necessary equipment and supply.
3. Mobilize resources and contract technical assistance to build the capacity of the central office staff and management.
4. Central office/and technical assistants provide support and guidance to the sub-national levels to set up the necessary structures and ensure operationalization.
5. Close monitoring of sub-national capacities; identify and effect tasks and powers for decentralization/delegation/de-concentration.

Develop standards and Detailed Operational Manuals

Description: this is a critical step in creating a transparent and accountable institution. Some of the issues that need to be addressed through operational manuals include:

- Organizational structure, governance structure and operation procedures for NHI.
- Details of benefit package.

- Service delivery arrangement and contractual arrangements with providers in order to change provider incentives and enable them respond to the new incentives as well as improve quality of health services.
- Revenue collection and Provider payment which include:
 - Registration of members, assessing income of self-employed, collection of contributions, etc.
 - Financial management (checking invoices and vouchers, paying, audits etc.),
- External monitoring of health insurance.
- Personnel administration and capacity building etc.
- Public relations and management of grievances.

Objectives: ensure transparent and accountable system of execution by developing standards (and modus operandi) for various operations of health insurance.

Key activities: the following key activities will be implemented towards developing detailed operational manuals.

1. Identify and package areas that need operational manuals.
2. Mobilize resources and procure consultancy service.
3. Ensure rigorous consultation with relevant stakeholders at critical points in the process of developing the operational manuals.
4. Finalize the manuals and get endorsement by relevant body.

N.B. since Namibia is already implementing PSEMAS and private health insurance schemes, not everything needs starting from scratch. Some of the existing operational manuals could be assessed and modified to fit into the new context.

Awareness Creation and Communication

Description: Effective awareness creation and communication machinery is a fundamental component of a functional health insurance system. Awareness creation should be provided continuously to relevant stakeholders at various milestones throughout the design and implementation of NHI. Effective communication insures buy-in and cooperation of key actors by facilitating discussion and clarification of issues relevant to diverse group of actors.

Depending on the types of health insurance models selected in Namibia, communication strategies should be tailored to specific target groups. For instance, for a voluntary based CBHI, continues and effective communication and promotion makes a lot of difference on the magnitude of enrolled population as compared to SHI which is mandatory for a defined category of formal sector employees. Effective communication for health insurance should also identify the right audience for specific message, use effective communication channel, be persuasive and behavior changing, and should result in a measurable desired impact on the targeted audience.

Objectives: promote continuous communication with beneficiaries and key actors in order to increase enrolment; enhance coverage and quality of health care for the ultimate achievement of universal health coverage for all Namibians.

Key activities: the following key activities will be implemented towards effective communication for health insurance.

1. Establish a permanent communication unit in the administrative structures of NHI.
2. Develop Communication strategy and tools.
3. Build capacity of communication units through training, equipping with the necessary technology and developing appropriate skills for forging linkages with relevant institutions (one option is to procure professional communication experts who could develop the tools and coach the staff).
4. Conduct continuous communication;
5. Conduct evaluation studies of communication, tools and improve the quality of communication on a continuous basis.

Collaborating with key Sectors for effective implementation of NHI

Description: The enacted law might end up establishing an autonomous body that manages the existing and new health insurance schemes in Namibia or provide a mandate to one of the existing institutions such as the SSC. In any case, effective implementation of health insurance requires strengthening of systems in key sectors other than the organization mandated to manage health insurance. Some of the systems that need to be revised and revamped include:

- Health service system (including defining catchment population, referral linkages, defining and implementing health facility standards (building, staff, equipment and supplies and SOPs), continuous quality improvement system, etc.).
- Health information systems (both within and outside the health sector).
- Regulatory system (financial liquidity; accreditation and licensing of service providers (service standard, staff norms and quality, ethical issues); customer complaint handling etc.).
- Public private partnerships.
- Community organizations and professional association; etc.

Objectives: to galvanize concerted effort among key sectors to establish a meaningful relationship so that relevant sectors will be able to implement critical system requirement for the effective scaling up of NHI in Namibia.

Key activities: the following key activities will be implemented towards effective multi-sectoral collaboration for health insurance.

1. Put health insurance top on the government policy agenda and ensure high level sponsorship.
2. Establish a health insurance board with representation of key stakeholders.
3. Map policy level challenges and use the board effectively to remove those challenges in various sectors.
4. Map technical challenges, establish technical committees and working groups from various sectors and provide the necessary support to tackle challenges.
5. Conduct continuous studies to assess policy and implementation challenges and use the results to improve the quality of interventions.